

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-028994

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH  
a. COUNTY  
**FILED JUL 31 1962**

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN  
**Saint Louis**

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION  
**Missouri Baptist Hosp**

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY

c. CITY OR TOWN  
**Saint Louis**

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
**5475 Cabanne Ave**

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

First Middle Last  
**GLADYS Chadwick MURPHY**

4. DATE OF DEATH  
Month Day Year  
**July 17 1962**

5. SEX  
**female**

6. COLOR OR RACE  
**white**

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
**Jan 28 1886- 76**

9. AGE (last birthday)  
IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Housewife**

10b. KIND OF BUSINESS OR INDUSTRY  
**-**

11. BIRTHPLACE (City and state or country)  
**Chicago Illinois**

12. CITIZEN OF WHAT COUNTRY  
**USA**

13a. FATHER'S NAME

**Oliver Chadwick**

13b. MOTHER'S MAIDEN NAME

**Florence Waller**

14. NAME OF HUSBAND OR WIFE

**Walter A. Murphy**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

17. INFORMANT  
Address  
**Oliver Chadwick 5475 Cabanne Ave**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Arteriosclerotic Heart disease with Atrial Fibrillation**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

**4200**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

**Diabetes Mellitus**

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE  
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **May 25, 1962** to **July 17, 1962** and last saw him/her alive on **July 16, 1962**  
Death occurred at **10:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

**Richard A. Jones MD**

**3720 Washington**

**7-17-62**

23a. BURIAL, CREMATION, REMOVAL (Specify)  
**7-20-62**

23b. DATE  
**Removal**

23c. NAME OF CEMETERY OR CREMATORY  
**Oak Grove Cemetery**

23d. LOCATION (City, town, or county) (State)  
**St. Louis Co. Mo**

24. FUNERAL DIRECTOR  
**Lupton Chapel inc 7233 Delmar Blvd**

ADDRESS

25. DATE RECD. BY LOCAL REG.  
**JUL 17 1962**

26. REGISTRAR'S SIGNATURE  
**Roan Smith. M.D.**

USE BLACK INK  
OR  
TYPEWRITER RIBBON

City

Murphy

Dr. Richa rd Jones  
3720 Washington

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dearence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.